

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3104

CERTIFICATE OF DEATH

05098

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>LIFE TIME</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>Bailey</u> Last <u>Princess Anne</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/5/1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u>78</u> Days <u>16</u> Hours <u>16</u> Min. <u>1958</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE WIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE JONES</u>		14. MOTHER'S MAIDEN NAME <u>HANNA HALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>[If yes, give war or dates of service]</u>		16. SOCIAL SECURITY NO. <u>ISAAC BAILEY PRINCESS ANNE, MD</u>	
17. INFORMANT <u>ISAAC BAILEY PRINCESS ANNE, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>20 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 26, 1958</u> , to <u>April 16, 1958</u> , that I last saw the deceased alive on <u>16 April</u> , 1958, and that death occurred at <u>11:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Eugene J. Linberg</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/20/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GRACE</u>		22d. LOCATION (City, town, or county) (State) <u>VENTON MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Jones Jr. Funeral Home</u>		24a. REC'D BY REGISTRAR <u>APR 21 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>W. H. Jones</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and medical history. The form is mostly blank with some faint markings.

BUREAU V. 1

APR 21 1938

RECEIVED

William J. [illegible]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

5152

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Willards</u>		d. STREET ADDRESS <u>RFD</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Thomas</u> Last <u>Baker</u>		4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6 1908</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Idora Baker</u>	
14. MOTHER'S MAIDEN NAME <u>Sattus Smith</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> If yes, give war or dates of service <u> </u>	
16. SOCIAL SECURITY NO. <u>218-20-6061</u>		17. INFORMANT <u>Idora Baker</u> Address <u>Willards, Md. RFD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driving car involved in a two car collision.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>1</u> M. <u>A.M.</u> <u>4-12-58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RFD # 50</u>	20f. (City or town) <u>Willards</u> (County) <u>Wicomico</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>4-12-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>4/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairlows</u>	22d. LOCATION (City, town, or county) (State) <u>Pittsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin Whaley</u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>APR 16 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU

APR 16 1958

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG228 5-9-58 at

Reg. Dist. No.

05100

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville		c. LENGTH OF STAY IN 1b X Pittsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Willis Middle B Last Ballentine		4. DATE OF DEATH Month 4 Day 29 Year 19 58	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?	
17. INFORMANT md State Police		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 490X (c) 2 days		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5-2-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-2-58	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Mem	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Booker M West		ADDRESS	
24a. REC'D BY REGISTRAR DATE MAY 5 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Lobar pneumonia

X

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

FILE NO. 114

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

BUREAU V. 3

APR 28 1958

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5106

CERTIFICATE OF DEATH

Reg. Dist. No. 05102

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>4 WKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA MARGARET Brittingham</u>		4. DATE OF DEATH Month Day Year <u>April 28 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 22, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRAILWAY BUS TERMINAL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ticket Agent</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HARRIETT LOCKERMAN</u>		14. MOTHER'S MAIDEN NAME <u>ELLA STRADLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>218-20-3906</u>	
17. INFORMANT Address <u>Arthur C. Brittingham, Salisbury, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Disease Acute</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>Recent acute infection</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/20</u> , 19 <u>58</u> , to <u>4/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/28</u> , 19 <u>58</u> , and that death occurred at <u>2:10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm B. Smith</u> M.D. <u>Med Center, Salisbury, Md</u> DATE SIGNED <u>4/28/58</u>			
PHYSICIAN'S NAME (Type) <u>William B. Smith SALISBURY, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/30/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson</u> ADDRESS <u>SALISBURY, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 30 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Norman T. Baker</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
MARRIOTT LOCKERMAN		APR 23 1958	
AGE		SEX	
38		M	
RACE		OCCUPATION	
W		TICKET AGENT	
MARRIAGE		PLACE OF BIRTH	
MARRIED		BALTIMORE, MD	
DATE OF MARRIAGE		PLACE OF DEATH	
APR 23 1958		BALTIMORE, MD	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL CAUSE	
CORONARY ARTERY DISEASE		SUICIDE	
MURDER		ACCIDENT	
OTHER		OTHER	

BUREAU V. E.

APR 30 1958

RECEIVED

Hill + Johnson Salisbury, Md.
4/30/58
William B Smith Salisbury, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G228, 4/25/58 fcy

CERTIFICATE OF DEATH

Reg. Dist. No.

05103

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PATTIE HUSTON BRITTINGHAM		4. DATE OF DEATH Month Day Year 4 18 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1869
9. AGE (In years or birthday) 88 1/2 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel J. Huston		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Miss Betty Farlow, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Gall Bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 18 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1957 , to April 18, 1958 , that I last saw the deceased alive on April 17, 1958 , and that death occurred at 12:50 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H.S. Kuhlman M.D.		ADDRESS (Street, city or town, state) Sharptown, Maryland DATE SIGNED 4/18/58	
PHYSICIAN'S NAME (Type) Dr. H.S. Kuhlman Sharptown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/20/58	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Salisbury, Maryland		24a. REC'D BY REGISTRAR APR 21 1958	
24b. REGISTRAR'S SIGNATURE Norman F. Baker			

Norman F. Baker

5107 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 4 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Levin Hayes Burris		4. DATE OF DEATH Month Day Year 4 20 1958	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-8-1905
9. AGE (In years lost birthday) yrs. 53		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Repairman		10b. KIND OF BUSINESS OR INDUSTRY Shoe Repair	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel James Burris		14. MOTHER'S MAIDEN NAME Anna E. Pinkett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 214-10-9831	
17. INFORMANT Mrs. Sarah Burris		Address 618 W. Isabella St. Salisbury Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Massive Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) 1 day INTERVAL BETWEEN ONSET AND DEATH 2nd/10/58		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 Apr. 1958 , to 20 Apr. 1958 , that I last saw the deceased alive on 20 Apr. 1958 , and that death occurred at 10:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. A. Purcell		ADDRESS (Street, city or town, state) 612 W. Main St. Salisbury, Md.	
PHYSICIAN'S NAME (Type) E. A. Purcell, M.D.		DATE SIGNED 25 Apr 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-28-1958	22c. NAME OF CEMETERY OR CREMATORY Green Acre Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Maryland		ADDRESS Salisbury, Maryland	
24a. REC'D BY REGISTRAR APR 28 '58		24b. REGISTRAR'S SIGNATURE W. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 28 1958

RECEIVED

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. R.

APR 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05106

5109

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Snow Hill Road</u>				d. STREET ADDRESS <u>7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Corbin</u> Last <u>Corbin</u>				4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1925</u>		9. AGE (In years last birthday) <u>33</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Jessie Corbin</u>				14. MOTHER'S MAIDEN NAME <u>Grace Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>WW2</u>		16. SOCIAL SECURITY NO. <u>218-12-1760</u>		17. INFORMANT <u>Ida Corbin</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driving car involved in a head on collision.</u>					
20c. TIME OF INJURY Month, Day, Year <u>9:45 a.m. 4-5-58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input type="checkbox"/> , <u>Accident</u> <input checked="" type="checkbox"/> , <u>Suicide</u> <input type="checkbox"/> , <u>Homicide</u> <input type="checkbox"/> , <u>Undetermined cause</u> <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>4-11-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-10-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hope Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker H. H. H.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 15 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. H. H.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF INTERVIEWEE	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWEE		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWEE		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWEE	
28. SIGNATURE OF INTERVIEWER		29. SIGNATURE OF INTERVIEWEE		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWEE		32. SIGNATURE OF INTERVIEWER		33. SIGNATURE OF INTERVIEWEE	
34. SIGNATURE OF INTERVIEWER		35. SIGNATURE OF INTERVIEWEE		36. SIGNATURE OF INTERVIEWER	
37. SIGNATURE OF INTERVIEWEE		38. SIGNATURE OF INTERVIEWER		39. SIGNATURE OF INTERVIEWEE	
40. SIGNATURE OF INTERVIEWER		41. SIGNATURE OF INTERVIEWEE		42. SIGNATURE OF INTERVIEWER	
43. SIGNATURE OF INTERVIEWEE		44. SIGNATURE OF INTERVIEWER		45. SIGNATURE OF INTERVIEWEE	
46. SIGNATURE OF INTERVIEWER		47. SIGNATURE OF INTERVIEWEE		48. SIGNATURE OF INTERVIEWER	
49. SIGNATURE OF INTERVIEWEE		50. SIGNATURE OF INTERVIEWER		51. SIGNATURE OF INTERVIEWEE	
52. SIGNATURE OF INTERVIEWER		53. SIGNATURE OF INTERVIEWEE		54. SIGNATURE OF INTERVIEWER	
55. SIGNATURE OF INTERVIEWEE		56. SIGNATURE OF INTERVIEWER		57. SIGNATURE OF INTERVIEWEE	
58. SIGNATURE OF INTERVIEWER		59. SIGNATURE OF INTERVIEWEE		60. SIGNATURE OF INTERVIEWER	
61. SIGNATURE OF INTERVIEWEE		62. SIGNATURE OF INTERVIEWER		63. SIGNATURE OF INTERVIEWEE	
64. SIGNATURE OF INTERVIEWER		65. SIGNATURE OF INTERVIEWEE		66. SIGNATURE OF INTERVIEWER	
67. SIGNATURE OF INTERVIEWEE		68. SIGNATURE OF INTERVIEWER		69. SIGNATURE OF INTERVIEWEE	
70. SIGNATURE OF INTERVIEWER		71. SIGNATURE OF INTERVIEWEE		72. SIGNATURE OF INTERVIEWER	
73. SIGNATURE OF INTERVIEWEE		74. SIGNATURE OF INTERVIEWER		75. SIGNATURE OF INTERVIEWEE	
76. SIGNATURE OF INTERVIEWER		77. SIGNATURE OF INTERVIEWEE		78. SIGNATURE OF INTERVIEWER	
79. SIGNATURE OF INTERVIEWEE		80. SIGNATURE OF INTERVIEWER		81. SIGNATURE OF INTERVIEWEE	
82. SIGNATURE OF INTERVIEWER		83. SIGNATURE OF INTERVIEWEE		84. SIGNATURE OF INTERVIEWER	
85. SIGNATURE OF INTERVIEWEE		86. SIGNATURE OF INTERVIEWER		87. SIGNATURE OF INTERVIEWEE	
88. SIGNATURE OF INTERVIEWER		89. SIGNATURE OF INTERVIEWEE		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWEE		92. SIGNATURE OF INTERVIEWER		93. SIGNATURE OF INTERVIEWEE	
94. SIGNATURE OF INTERVIEWER		95. SIGNATURE OF INTERVIEWEE		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWEE		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWEE	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWEE		102. SIGNATURE OF INTERVIEWER	

BUREAU V. B.

APR 15 1958

RECEIVED

5110

CERTIFICATE OF DEATH

05107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIVERSIDE NURSING HOME</u>		d. STREET ADDRESS <u>MARKET STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>POLK</u> Last <u>CROCKETT</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 6, 1867</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM SAMUEL CARR POLK</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET ANN POWELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS R.T. TALTON, Pocomoke City, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Atherosclerosis</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Insufficiency, Arteriosclerotic Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of it, if any) <u>Heart Disease</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19, 1954</u> to <u>4/23, 1958</u> , that I last saw the deceased alive on <u>4-23, 1958</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>April 24, 1958</u>	
PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE</u>		<u>SALISBURY, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-26-58</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>BETHANY METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Watson</u> ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>APR 29 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU W. H.

APR 29 1938

RECEIVED

APR 28 1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5111

CERTIFICATE OF DEATH

Reg. Dist. No. 05108

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN TB <u>2 Wks.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>	
d. STREET ADDRESS <u>1 616 Pinehurst Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES MYRON DASHIELL</u>		4. DATE OF DEATH Month Day Year <u>4 1 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9, 1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Broker</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles I. Dashiell</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Bothum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-14-2016</u>	
17. INFORMANT Address <u>Mrs. Lula W. Dashiell, Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastric tumor</u> (c) <u>Gastric ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-1-58</u> , to <u>4-1-58</u> , that I last saw the deceased alive on <u>4-1-58</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>4/2/58</u>	
ACTUAL SIGNATURE <u>Philip A. Insley</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Dr. Philip A. Insley 116 East Main St., Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/3/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park Salisbury, Maryland</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hill & Johnson Co. Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Norman F. Baker</u>			

4

2018-19

BUREAU V. 4

1958 3 APR

RECEIVED

5112 CERTIFICATE OF DEATH

Reg. Dist. No.

05109

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>12</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		d. STREET ADDRESS <i>#69 Camden Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>EARNEST</i> Middle <i>L</i> Last <i>ESHAM</i>		4. DATE OF DEATH Month <i>APRIL</i> Day <i>18</i> Year <i>1958</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 4, 1874</i>
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	IF UNDER 24 HRS. Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Gardner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gardning</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Levin Esham</i>		14. MOTHER'S MAIDEN NAME <i>Mahala Brumbley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unk</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Mrs. Harry D. Kenney (Daughter)</i>		Address <i>#69 Camden Ave. Salisbury, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO <i>Cerebral Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO <i></i> (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>Unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary Artery Heart Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <i></i> Day <i></i> Year <i>19</i> Hour <i></i> a. p. <i></i> p. m. <i></i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan. 1958</i> to <i>April 18, 1958</i> that I last saw the deceased alive on <i>April 18, 1958</i> and that death occurred at <i>3:30</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>David J. Gilmore</i> M.D.		DATE SIGNED <i>Salisbury Md. April 18, 1958</i>	
PHYSICIAN'S NAME (Type) <i>Dr. David J. Gilmore</i>		<i>Medical Center Salisbury, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr. 20, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Parsonsburg Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Barsonsburg, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLOWAY & COMPANY</i>		ADDRESS <i>SALISBURY MARYLAND</i>	
24a. REC'D BY REGISTRAR <i>APR 21 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. Esham</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CLERGYMAN		16. SIGNATURE OF JUDGE	
17. SIGNATURE OF CORONER		18. SIGNATURE OF SHERIFF		19. SIGNATURE OF TOWNSHIP CLERK		20. SIGNATURE OF COUNTY CLERK	
21. SIGNATURE OF STATE CLERK		22. SIGNATURE OF U.S. MARSHAL		23. SIGNATURE OF U.S. ATTORNEY		24. SIGNATURE OF U.S. SENATOR	
25. SIGNATURE OF U.S. REPRESENTATIVE		26. SIGNATURE OF U.S. SENATOR		27. SIGNATURE OF U.S. REPRESENTATIVE		28. SIGNATURE OF U.S. SENATOR	
29. SIGNATURE OF U.S. REPRESENTATIVE		30. SIGNATURE OF U.S. SENATOR		31. SIGNATURE OF U.S. REPRESENTATIVE		32. SIGNATURE OF U.S. SENATOR	
33. SIGNATURE OF U.S. REPRESENTATIVE		34. SIGNATURE OF U.S. SENATOR		35. SIGNATURE OF U.S. REPRESENTATIVE		36. SIGNATURE OF U.S. SENATOR	
37. SIGNATURE OF U.S. REPRESENTATIVE		38. SIGNATURE OF U.S. SENATOR		39. SIGNATURE OF U.S. REPRESENTATIVE		40. SIGNATURE OF U.S. SENATOR	
41. SIGNATURE OF U.S. REPRESENTATIVE		42. SIGNATURE OF U.S. SENATOR		43. SIGNATURE OF U.S. REPRESENTATIVE		44. SIGNATURE OF U.S. SENATOR	
45. SIGNATURE OF U.S. REPRESENTATIVE		46. SIGNATURE OF U.S. SENATOR		47. SIGNATURE OF U.S. REPRESENTATIVE		48. SIGNATURE OF U.S. SENATOR	
49. SIGNATURE OF U.S. REPRESENTATIVE		50. SIGNATURE OF U.S. SENATOR		51. SIGNATURE OF U.S. REPRESENTATIVE		52. SIGNATURE OF U.S. SENATOR	
53. SIGNATURE OF U.S. REPRESENTATIVE		54. SIGNATURE OF U.S. SENATOR		55. SIGNATURE OF U.S. REPRESENTATIVE		56. SIGNATURE OF U.S. SENATOR	
57. SIGNATURE OF U.S. REPRESENTATIVE		58. SIGNATURE OF U.S. SENATOR		59. SIGNATURE OF U.S. REPRESENTATIVE		60. SIGNATURE OF U.S. SENATOR	
61. SIGNATURE OF U.S. REPRESENTATIVE		62. SIGNATURE OF U.S. SENATOR		63. SIGNATURE OF U.S. REPRESENTATIVE		64. SIGNATURE OF U.S. SENATOR	
65. SIGNATURE OF U.S. REPRESENTATIVE		66. SIGNATURE OF U.S. SENATOR		67. SIGNATURE OF U.S. REPRESENTATIVE		68. SIGNATURE OF U.S. SENATOR	
69. SIGNATURE OF U.S. REPRESENTATIVE		70. SIGNATURE OF U.S. SENATOR		71. SIGNATURE OF U.S. REPRESENTATIVE		72. SIGNATURE OF U.S. SENATOR	
73. SIGNATURE OF U.S. REPRESENTATIVE		74. SIGNATURE OF U.S. SENATOR		75. SIGNATURE OF U.S. REPRESENTATIVE		76. SIGNATURE OF U.S. SENATOR	
77. SIGNATURE OF U.S. REPRESENTATIVE		78. SIGNATURE OF U.S. SENATOR		79. SIGNATURE OF U.S. REPRESENTATIVE		80. SIGNATURE OF U.S. SENATOR	
81. SIGNATURE OF U.S. REPRESENTATIVE		82. SIGNATURE OF U.S. SENATOR		83. SIGNATURE OF U.S. REPRESENTATIVE		84. SIGNATURE OF U.S. SENATOR	
85. SIGNATURE OF U.S. REPRESENTATIVE		86. SIGNATURE OF U.S. SENATOR		87. SIGNATURE OF U.S. REPRESENTATIVE		88. SIGNATURE OF U.S. SENATOR	
89. SIGNATURE OF U.S. REPRESENTATIVE		90. SIGNATURE OF U.S. SENATOR		91. SIGNATURE OF U.S. REPRESENTATIVE		92. SIGNATURE OF U.S. SENATOR	
93. SIGNATURE OF U.S. REPRESENTATIVE		94. SIGNATURE OF U.S. SENATOR		95. SIGNATURE OF U.S. REPRESENTATIVE		96. SIGNATURE OF U.S. SENATOR	
97. SIGNATURE OF U.S. REPRESENTATIVE		98. SIGNATURE OF U.S. SENATOR		99. SIGNATURE OF U.S. REPRESENTATIVE		100. SIGNATURE OF U.S. SENATOR	

BUREAU V. S.

APR 21 1958

RECEIVED

5113 CERTIFICATE OF DEATH

Reg. Dist. No. 05110

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. STREET ADDRESS <u>103 Pineway</u>			
3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>Elizabeth</u> Last <u>Evans</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/2/1883</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Millard Filmore Evans</u>				14. MOTHER'S MAIDEN NAME <u>Heneritta White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unk.</u>				16. SOCIAL SECURITY NO. <u>?</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>Mrs. Blanche Bozman-Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>332x</u> IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, general</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>April 15, 1958</u> , to <u>April 20, 1958</u> , that I last saw the deceased alive on <u>April 20, 1958</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>L. V. Maldve</u> M.D. <u>Deer's Head State Hospital</u> <u>4/21/58</u> PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u> <u>Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 23, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>W. B. Beach</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

APR 25 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05111

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Wicomico 5155 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b X Fruitland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 3		e. STREET ADDRESS P.O.B.#	
3. NAME OF DECEASED (Type or print) First THURMAN Middle RANDOLPH Last FARLOW		4. DATE OF DEATH Month APRIL Day 7 th Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1906
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee of Shirt Factory		10b. KIND OF BUSINESS OR INDUSTRY Salisbury, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Randolph Farlow		14. MOTHER'S MAIDEN NAME Mannie Malone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs. Lottie P. Farlow (Wife) Fruitland Md.	
17. INFORMANT Mrs. Lottie P. Farlow (Wife) Fruitland Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)	
19. INTERVAL BETWEEN ONSET AND DEATH minutes		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) garden hose from exhaust into auto	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) garden hose from exhaust into auto	
20c. TIME OF INJURY Month, Day, Year 4-7-58 Hour 11 a.m. 4-7 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) farm		20f. CITY OR TOWN (County) (State) Salisbury Wicomico	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		DATE SIGNED April 9 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 11, 1958	
22c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		22d. LOCATION (City, town, or county) (State) Near Fruitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR APR 11 '58		24b. REGISTRAR'S SIGNATURE Alfred...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 14
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
APR 11 1938
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5114 CERTIFICATE OF DEATH

05112

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HEZEKIAH</u> First <u>FINNEY</u> Middle Last				4. DATE OF DEATH <u>APRIL 14</u> Month Day Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Catherine Haves</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>593X</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Nephritis + Uremia + Anasarca</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 11</u> , 19 <u>58</u> , to <u>April 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 14</u> , 19 <u>58</u> , and that death occurred at <u>10:55</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Pine Bluff Road</u> DATE SIGNED <u>4/14/58</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-19-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Rockton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boake Albeck</u> ADDRESS				24a. REC'D BY REGISTRAR <u>APR 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Albeck</u>	

APR 22 1958.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial/transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05113

CERTIFICATE OF DEATH

5115

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Prince George's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 6/25/57</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		<u>16152</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Bernard Jesse Gates</u>				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>28</u> (Year) <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married(sep)</u>	8. DATE OF BIRTH <u>Jan. 28, 1909</u>	9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jesse Gates</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Baldwin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Nat. Guard 1926-36 unknown</u>		17. INFORMANT & ADDRESS <u>Records of Pine Bluff State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1</u> , 19 <u>47</u> , to <u>April 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 27</u> , 19 <u>58</u> , and that death occurred at <u>5:32a</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edward P. Ritchey</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>4/28/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5-2-58</u>		NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>	
24. REC'D BY REGISTRAR DATE <u>MAY 1 '58</u>		REGISTRAR'S SIGNATURE <u>Allen Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u> ADDRESS <u>1400 Chapin St N.W.</u>			

EXHIBIT/IN

NOTICE: This is a copy of the original document. It is not to be used for legal purposes. The original document is the only one to be used for legal purposes. The original document is the only one to be used for legal purposes.

CERTIFICATE OF DEATH

FILE

Reg. No. 100

1. NAME OF DECEASED

2. SEX

3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. EDUCATION
9. RELIGION
10. RACE
11. COLOR
12. SEX OF CHILDREN
13. DATE OF DEATH
14. PLACE OF DEATH
15. CAUSE OF DEATH
16. MANNER OF DEATH
17. SIGNATURE OF PHYSICIAN
18. SIGNATURE OF REGISTRAR
19. SIGNATURE OF WITNESSES
20. SIGNATURE OF DECEASED
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05114

5116 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ERNEST Middle WASHINGTON Last GIVANS		4. DATE OF DEATH Month APRIL Day 21 st Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 9 Days 10 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Whiton, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Elisha Givans	
14. MOTHER'S MAIDEN NAME Elizabeth Parsons		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Maurice F. Farlow (Daughter) 316 Naylor St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal hemorrhage DUE TO 2043 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		INTERVAL BETWEEN ONSET AND DEATH Sudden Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-8-54 , 19 , to 4-21-58 , 19 , that I last saw the deceased alive on 4-21-58 , 19 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 			
ACTUAL SIGNATURE Earl L. Royer M.D. 			
PHYSICIAN'S NAME (Type) Dr. Earl L. Royer 407 Camden Ave. Salisbury, Maryland 4/ 22/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 24, 1958	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR 	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE 	
DATE APR 25 1958			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. 8.

APR 25 1958

RECEIVED

5117

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> 468-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>523 King Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Gunby</u> Last <u>Gunby</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>OCT 31, 1895</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAW MILL</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Short</u>		14. MOTHER'S MAIDEN NAME <u>Effie Adkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>222-24-1971</u>	
17. INFORMANT <u>Mr. George T. Carey</u>		Address <u>Laurel Del</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Vascular Collapse</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Embraced Arteriosclerosis</u> DUE TO (c) <u>Chronic Cholelithiasis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4:17</u> , 19 <u>58</u> , to <u>4:27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4:27</u> , 19 <u>58</u> , and that death occurred at <u>7:22 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. H. Briele</u>		ADDRESS (Street, city or town, state) <u>Medical Center</u>	
PHYSICIAN'S NAME (Type) <u>H. H. Briele</u>		DATE SIGNED <u>4-27-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/1/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ODD Fellows Cem</u>		22d. LOCATION (City, town, or county) (State) <u>LAUREL DEL</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Briele</u>		ADDRESS <u>Laurel Delaware</u>	
24a. REC'D BY REGISTRAR <u>APR 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

APR 30 1958

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05116

5118

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				3. NAME OF DECEASED (Type or print) First Robert Middle Halligan Last Halligan			
4. DATE OF DEATH Month April Day 14, Year 19 58				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH July 29, 1898				9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital orderly				10b. KIND OF BUSINESS OR INDUSTRY unemployed			
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Robert Patrick Halligan				14. MOTHER'S MAIDEN NAME Annie Leonard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service) --				16. SOCIAL SECURITY NO. --			
17. INFORMANT Deer's Head Hospital, Salisbury, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial asthma 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease							
INTERVAL BETWEEN ONSET AND DEATH Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 7th, 19 58 , to April 14, 19 58 , that I last saw the deceased alive on April 14, 19 58 , and that death occurred at 3:05 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE G. Kosmahly M.D. Deer's Head State Hospital 4/14/58							
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF Apr. 17, 1958							
22c. NAME OF CEMETERY OR CREMATORY New Cathedral							
22d. LOCATION (City, town, or county) (State) Baltimore Maryland.							
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Wears & Son							
ADDRESS 805 N. Calvert Street							
24a. REC'D BY REGISTRAR APR 16 '58							
24b. REGISTRAR'S SIGNATURE Alfred Smith							

91

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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Form 100-100

1958



1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. MARITAL STATUS		10. OCCUPATION		11. EDUCATION		12. RELIGION		13. SOCIAL SECURITY NUMBER		14. MANNER OF DEATH		15. CAUSE OF DEATH		16. PLACE OF INTERMENT	

unemployed

hospital orderly

17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESS		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF REGISTRAR		21. SIGNATURE OF CLERK		22. SIGNATURE OF JUDGE		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF CORONER	

BUREAU V. E.

APR 16 1958

RECEIVED

[Handwritten signature]

RECEIVED
APR 16 1958
BUREAU V. E.

CERTIFICATE OF DEATH

5119

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u> <u>23x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springhill Sanitarium</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>AMELIA</u> Last <u>HANCOCK</u> <u>Mrs. Annie Amelia Hancock</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 5, 1866</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>William F. Trader</u>	
14. MOTHER'S MAIDEN NAME <u>Loretta Paradise</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Harold D. Cutright, Stockton, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 2</u> , 19 <u>58</u> , to <u>April 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 1</u> , 19 <u>58</u> , and that death occurred at <u>5:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip A. Insley</u>		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>4-5-58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Philip A. Insley</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-7-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenbackville M.E.</u>	22d. LOCATION (City, town, or county) (State) <u>Rural Stockton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Stedman</u>		ADDRESS <u>Pocomoke City, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hedden</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU 15

RECEIVED

5120

CERTIFICATE OF DEATH

Reg. Dist. No. 05118

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>28 days</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GIRDLER TREE</u> <u>23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Abraham M. Harmon</u>		4. DATE OF DEATH Month Day Year <u>APRIL 21 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Belong</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>April 30 1880</u>	9. AGE (In years last birthday) <u>77 1/2</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wideman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipyard Bay Bridge Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Harmon</u>		14. MOTHER'S MAIDEN NAME <u>Miss Alice Bell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-16-8539</u>	
17. INFORMANT <u>Mrs Rachel Harmon, Girdler Tree, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-25-</u> , 19 <u>58</u> ; to <u>4-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-21</u> , 19 <u>58</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Ellis Jr</u> M.D.		DATE SIGNED <u>4-21-58</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>April 26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Coolidge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Girdler Tree, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Ellis Jr</u>		ADDRESS <u>Salisbury, Md</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>PR 25 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John A. Smith*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF BIRTH: *Jan 15, 1910*

5. PLACE OF BIRTH: *St. Louis, Mo.*

6. OCCUPATION: *Engineer*

7. MARITAL STATUS: *Married*

8. DATE OF DEATH: *Apr 10, 1958*

9. PLACE OF DEATH: *Home*

10. CAUSE OF DEATH: *Heart Disease*

11. SIGNATURE OF PHYSICIAN: *[Signature]*

12. SIGNATURE OF REGISTRAR: *[Signature]*

BUREAU V. 2

APR 25 1958

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> 23X-2	<input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 12</u>		d. STREET ADDRESS <u>210 Walnut</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ora</u> Middle <u>Lee</u> Last <u>Harris</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7 - 1943</u>
9. AGE (In years last birthday) <u>14 5/8</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>12</u> Hours <u>28</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>	
11. BIRTHPLACE (State or foreign country) <u>Chincoteague, Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Edward Harris</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Syndall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Robert Edward Harris, Snow Hill md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull</u> DUE TO <u>816X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERNAL BETWEEN ONSET AND DEATH <u>fracture</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Head on collision two cars</u>	
20c. TIME OF INJURY Hour <u>9:45</u> a.m. <u>4-5</u> p.m. <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt 12</u>	20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial April 9/58</u>		22b. DATE THEREOF <u>April 9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bates Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Harris</u>		ADDRESS <u>Snow Hill, md</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Harris</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

APR 9 1958

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

5121

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> <u>46X-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Guy</u> Last <u>Hastings</u>				4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-21-1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u>20</u> Min. <u>58</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Joseph Hastings</u>				14. MOTHER'S MAIDEN NAME <u>Marietta Gordy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>XXX</u>		17. INFORMANT <u>Etta Elliott, Delmar, Del.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>491X</u> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>9040 Fractured right humerus.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home on 4-7-58.</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>4-7-58</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>R F D</u> (County) <u>Sussex</u> (State) <u>Del.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>				DATE SIGNED <u>4-21-58</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-23-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		22d. LOCATION (City, town, or county) <u>Delmar, Del.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marshall</u> ADDRESS <u>Delmar, Del.</u>				24a. REC'D BY REGISTRAR <u>W. S. Marshall</u> DATE <u>APR 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Marshall</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 23 1958

5122

CERTIFICATE OF DEATH

05121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Private Sanitarium				e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First HELEN Middle MARGUERITE Last HASTINGS				4. DATE OF DEATH Month April Day 13th Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23, 1896	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Michaels, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME John H. Blades				14. MOTHER'S MAIDEN NAME Susan Bloodsworth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr Stanley L. Hastings (Husband)				Address R.D.# 1 Meadow Bridge Rd., Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 3 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury				20g. (County) Wicomico		20h. (State) Md	
21. I certify that I attended the deceased from May 1957 to April 13, 1958 that I last saw the deceased alive on April 13, 1958 , and that death occurred at 7:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Alberta Mattax				DATE SIGNED 4/17/58			
PHYSICIAN'S NAME (Type) Dr. Alberta Mattax				ADDRESS Camden Ave. Salisbury, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 16, 1958		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE APR 18 '58	
24b. REGISTRAR'S SIGNATURE Al. Beach							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White		DATE OF DEATH April 18, 1958	
PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
OCCUPATION Salesman		EDUCATION High School		MARRIAGE Married		RELIGION Roman Catholic		BIRTH DATE April 18, 1913	
FATHER'S NAME John H. Harris		MOTHER'S NAME Mary E. Harris		BIRTH PLACE Baltimore, Md.		CITY OF BIRTH Baltimore		STATE OF BIRTH Maryland	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		IMMEDIATE CAUSE Coronary Thrombosis		UNDERLYING CAUSE Atherosclerosis		OTHER CAUSES None	
DATE OF BURIAL April 20, 1958		PLACE OF BURIAL St. Ignace Cemetery		CITY OF BURIAL Baltimore		STATE OF BURIAL Maryland		COUNTRY OF BURIAL United States	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN John H. Harris		SIGNATURE OF PHYSICIAN Dr. J. H. Harris		SIGNATURE OF CLERK J. H. Harris		SIGNATURE OF REGISTRAR J. H. Harris	

BUREAU V. S.

Apr 18 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5123 CERTIFICATE OF DEATH

05122

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 yr 4½ mo.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield 1939.2		d. STREET ADDRESS Chesapeake Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle T. Last Heck		4. DATE OF DEATH Month April Day 11 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1878
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas James Conner		14. MOTHER'S MAIDEN NAME Annie Handy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 215 10 5771 D	
17. INFORMANT Deer's Head Hospital, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular Dis. DUE TO (c) Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recurrent cerebral thrombosis INTERVAL BETWEEN ONSET AND DEATH 8 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 28, 1956 , to April 11, 1958 , that I last saw the deceased alive on April 11, 1958 , and that death occurred at 7:28 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 4/11/58 ACTUAL SIGNATURE L. V. Maldre M.D. PHYSICIAN'S NAME (Type) L. V. Maldre, M. D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 13, 1958	
22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons—Crisfield, Md.		24a. REC'D BY REGISTRAR DATE APR 14 '58	
24b. REGISTRAR'S SIGNATURE W. H. Beach			

CERTIFICATE OF DEATH

5153

1-14-58

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH APR 4 1968	
PLACE OF DEATH BALTIMORE, MD		AGE 35	
SEX Male		RACE White	
MANNER OF DEATH Suicide		CAUSE OF DEATH Gunshot wound	
DISEASE OR INJURY Depression		TREATMENT None	
DATE OF BIRTH APR 14 1933		PLACE OF BIRTH Memphis, Tenn	
OCCUPATION None		EDUCATION High School	
MARITAL STATUS Single		RELIGION None	
SIGNED BY JAMES EARL RAY		WITNESSED BY None	
DATE APR 4 1968		PLACE BALTIMORE, MD	

RECEIVED
APR 14 1968
BUREAU V. E.

APR 15 1968
JAMES EARL RAY
BALTIMORE, MD

5124

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 608 Oak Hill Ave				d. STREET ADDRESS 608 Oak Hill Ave			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First AUDREY Middle JEWELL Last HOSTETTER		4. DATE OF DEATH		Month APRIL Day 2nd Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1913		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Baylus McComas				14. MOTHER'S MAIDEN NAME (KMK) Etta - - -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 		17. INFORMANT Mr. Garry L. Hostetter (Husband) Address 608 Oak Hill Ave. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Long pulmonary edema 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congestive heart failure DUE TO (c) degenerative heart disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5-6-57 , 19 57 , to 4/2 , 19 58 , that I last saw the deceased alive on 4/2 , 19 58 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Earl Beardsley M.D. Garry L. Hostetter				DATE SIGNED 4/2/58			
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley Maryland Ave. Salisbury, Md. Apr. 2/58							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Apr. 6, 1958		Wicomico Memorial Park		Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND				24a. REC'D BY REGISTRAR DATE APR 7 '58		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UREAU V. B.

1958 4 20

RECEIVED

CERTIFICATE OF DEATH

5157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Wicomico COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke		c. LENGTH OF STAY IN 1b 86 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Nanticoke	
3. NAME OF DECEASED (Type or print) Elwood John Jones		4. DATE OF DEATH April 13 1958	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-1872
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman		10b. KIND OF BUSINESS OR INDUSTRY retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jones		14. MOTHER'S MAIDEN NAME Mary Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Ella Hardy Nanticoke, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1947 to 13 April 1958 , that I last saw the deceased alive on 13 April 1958 , and that death occurred at 5 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Nanticoke, Md. DATE SIGNED 4/17/58			
ACTUAL SIGNATURE Robert H. Sanders M.D.		PHYSICIAN'S NAME (Type) Robert H. Sanders	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 418-1958	
22c. NAME OF CEMETERY OR CREMATORY Nanticoke Cemetery		22d. LOCATION (City, town, or county) (State) Nanticoke, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Levin B. Wilson ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR APR 21 1958 24b. REGISTRAR'S SIGNATURE W. J. Edlich	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05125

5125 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>155 Delaware Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Infant Barnett King Jr.</u>		4. DATE OF DEATH Month Day Year <u>April 25 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasoid</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1958 - 11:12 AM</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>1 20 33</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Barnett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lee Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Barnett King</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Prematurity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/23</u> , 19 <u>58</u> , to <u>4/25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/25</u> , 19 <u>58</u> , and that death occurred at <u>7:45 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center, Salisbury, Md</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>4/25/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-30-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brown Here Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Becker M. Wick</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>MAY 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	

2082204XVO

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05126

CERTIFICATE OF DEATH

Reg. Dist. No.

5126

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>Since 3/25/58</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Upper Fairmount</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Lottie May Lattimore</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 21 19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>December 11, 1881</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Beauchamp</u>				14. MOTHER'S MAIDEN NAME <u>Indiana Dryden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Records of Pine Bluff State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
002X IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>17 years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 25</u> , 19 <u>58</u> , to <u>April 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 21</u> , 19 <u>58</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>E. Pitcher</u>		M.D.		ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>4/21/58</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-23-58</u>		NAME OF CEMETERY OR CREMATORY <u>Fairmount Cemetery</u>		LOCATION (City, town, or county) <u>Fairmount Md.</u>	
24. REC'D BY REGISTRAR DATE <u>APR 24 '58</u>		REGISTRAR'S SIGNATURE <u>W. J. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Levin B. Wilson</u>		ADDRESS <u>Primer Ave</u>	

SHORTSHEET

1. This is a copy of a form as supplied under all instructions of the BUREAU OF VITAL STATISTICS, DEPARTMENT OF HEALTH, and is not to be used for any other purpose. It is to be filled out by the person who has the information, and is to be submitted to the BUREAU OF VITAL STATISTICS, DEPARTMENT OF HEALTH, for filing. It is not to be used for any other purpose.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. FULL NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF DISTRICT ATTORNEY

19. SIGNATURE OF CLERK

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF CORONER

24. SIGNATURE OF DISTRICT ATTORNEY

25. SIGNATURE OF CLERK

26. SIGNATURE OF JURY

27. SIGNATURE OF JUDGE

28. SIGNATURE OF SHERIFF

29. SIGNATURE OF CORONER

30. SIGNATURE OF DISTRICT ATTORNEY

31. SIGNATURE OF CLERK

32. SIGNATURE OF JURY

33. SIGNATURE OF JUDGE

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF CORONER

36. SIGNATURE OF DISTRICT ATTORNEY

37. SIGNATURE OF CLERK

38. SIGNATURE OF JURY

39. SIGNATURE OF JUDGE

39. SIGNATURE OF SHERIFF

40. SIGNATURE OF CORONER

40. SIGNATURE OF DISTRICT ATTORNEY

41. SIGNATURE OF CLERK

41. SIGNATURE OF JURY

42. SIGNATURE OF JUDGE

42. SIGNATURE OF SHERIFF

43. SIGNATURE OF CORONER

43. SIGNATURE OF DISTRICT ATTORNEY

44. SIGNATURE OF CLERK

44. SIGNATURE OF JURY

45. SIGNATURE OF JUDGE

45. SIGNATURE OF SHERIFF

46. SIGNATURE OF CORONER

46. SIGNATURE OF DISTRICT ATTORNEY

47. SIGNATURE OF CLERK

47. SIGNATURE OF JURY

48. SIGNATURE OF JUDGE

48. SIGNATURE OF SHERIFF

49. SIGNATURE OF CORONER

49. SIGNATURE OF DISTRICT ATTORNEY

50. SIGNATURE OF CLERK

50. SIGNATURE OF JURY

51. SIGNATURE OF JUDGE

51. SIGNATURE OF SHERIFF

52. SIGNATURE OF CORONER

52. SIGNATURE OF DISTRICT ATTORNEY

53. SIGNATURE OF CLERK

53. SIGNATURE OF JURY

54. SIGNATURE OF JUDGE

54. SIGNATURE OF SHERIFF

55. SIGNATURE OF CORONER

55. SIGNATURE OF DISTRICT ATTORNEY

56. SIGNATURE OF CLERK

56. SIGNATURE OF JURY

57. SIGNATURE OF JUDGE

57. SIGNATURE OF SHERIFF

58. SIGNATURE OF CORONER

58. SIGNATURE OF DISTRICT ATTORNEY

59. SIGNATURE OF CLERK

59. SIGNATURE OF JURY

60. SIGNATURE OF JUDGE

60. SIGNATURE OF SHERIFF

61. SIGNATURE OF CORONER

BUREAU V. S.

APR 24 1939

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5127

CERTIFICATE OF DEATH

05127

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>10 days</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula Memorial Hospital</u>		d. STREET ADDRESS <u>206 Talbot Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harland Alfred LeCompte</u>		4. DATE OF DEATH Month Day Year <u>APRIL 10, 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1900</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman for oil distrs.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vienna</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lloyd S. LeCompte</u>		14. MOTHER'S MAIDEN NAME <u>Robert Edna Price</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No Yes World War 1</u>		16. SOCIAL SECURITY NO. <u>214-07-8203</u>	
17. INFORMANT Address <u>Mrs. Mary W. LeCompte, 206 Talbot Ave., Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>2 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 30, 1958</u> , to <u>APRIL 9, 1958</u> , that I last saw the deceased alive on <u>APRIL 9, 1958</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gibson</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>April 10, 1958</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 12, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth P. Thomas</u> ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 14 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u>	

WYOMING STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

BUREAU V. S.

APR 14 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05128
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS R F D # 2 Scotts Camp	
3. NAME OF DECEASED (Type or print) First Middle Last Charles F Lewis		4. DATE OF DEATH Month Day Year 4 20 19 58	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-45
9. AGE (In years last birthday) 12 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Ayers		14. MOTHER'S MAIDEN NAME Louise Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Louise Lewis, Scotts Camp, Salisbury, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped into water and failed to surface.	
20c. TIME OF INJURY Month, Day, Year 3:20 P.M. 4-20-58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Johnsons Pond Salisbury Wicomico Md.	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/27/58	
22c. NAME OF CEMETERY OR CREMATORY CHURCH		22d. LOCATION (City, town, or county) (State) NEW YORK MD	
23. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart		24a. REC'D BY REGISTRAR APR 28 '58	
ADDRESS Md.		24b. REGISTRAR'S SIGNATURE W. H. Smith	

RECEIVED

APR 28 1958

BUREAU V. 3

FOR STATE
HEALTH DEPT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5158

CERTIFICATE OF DEATH

05129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing Home				d. STREET ADDRESS W. State Street			
3. NAME OF DECEASED (Type or print) First Lillian Middle Eley Last Lindley				4. DATE OF DEATH Month April Day 4 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 25, 1867	
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY At Home			
13. FATHER'S NAME Michael Eley				14. MOTHER'S MAIDEN NAME Winnie Watkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Lucy Sparrow, Delmar, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) senility DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 10 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 4/4, 1958 to 19 , that I last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph A. Elliott				ADDRESS (Street, city or town, state) Delmar, Del.			
PHYSICIAN'S NAME (Type) JOSEPH A. ELLIOTT				DATE SIGNED 4/6/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-7-58		22c. NAME OF CEMETERY OR CREMATORY First Methodist		22d. LOCATION (City, town, or county) (State) Delmar, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE W.S. Grand Co - Delmar, Del				24a. REC'D BY REGISTRAR DATE APR 8 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

CERTIFICATE OF DEATH

5522

Form 100-10

1. NAME OF DECEASED JOHN J. JONES		2. SEX MALE		3. AGE 45		4. RACE WHITE	
5. DATE OF DEATH APR 10 1958		6. TIME OF DEATH 10:15 AM		7. PLACE OF DEATH HOME		8. CITY BALTIMORE	
9. COUNTY JOHNS HOPKINS		10. STATE MARYLAND		11. ZIP CODE 21201		12. MARRIAGE 1925	
13. OCCUPATION ENGINEER		14. CAUSE OF DEATH HEART DISEASE		15. MANNER OF DEATH NATURAL		16. SIGNATURE OF PHYSICIAN J. J. JONES	
17. SIGNATURE OF DECEASED J. J. JONES		18. SIGNATURE OF WITNESS J. J. JONES		19. SIGNATURE OF DECEASED J. J. JONES		20. SIGNATURE OF WITNESS J. J. JONES	
21. SIGNATURE OF DECEASED J. J. JONES		22. SIGNATURE OF WITNESS J. J. JONES		23. SIGNATURE OF DECEASED J. J. JONES		24. SIGNATURE OF WITNESS J. J. JONES	
25. SIGNATURE OF DECEASED J. J. JONES		26. SIGNATURE OF WITNESS J. J. JONES		27. SIGNATURE OF DECEASED J. J. JONES		28. SIGNATURE OF WITNESS J. J. JONES	
29. SIGNATURE OF DECEASED J. J. JONES		30. SIGNATURE OF WITNESS J. J. JONES		31. SIGNATURE OF DECEASED J. J. JONES		32. SIGNATURE OF WITNESS J. J. JONES	
33. SIGNATURE OF DECEASED J. J. JONES		34. SIGNATURE OF WITNESS J. J. JONES		35. SIGNATURE OF DECEASED J. J. JONES		36. SIGNATURE OF WITNESS J. J. JONES	
37. SIGNATURE OF DECEASED J. J. JONES		38. SIGNATURE OF WITNESS J. J. JONES		39. SIGNATURE OF DECEASED J. J. JONES		40. SIGNATURE OF WITNESS J. J. JONES	
41. SIGNATURE OF DECEASED J. J. JONES		42. SIGNATURE OF WITNESS J. J. JONES		43. SIGNATURE OF DECEASED J. J. JONES		44. SIGNATURE OF WITNESS J. J. JONES	
45. SIGNATURE OF DECEASED J. J. JONES		46. SIGNATURE OF WITNESS J. J. JONES		47. SIGNATURE OF DECEASED J. J. JONES		48. SIGNATURE OF WITNESS J. J. JONES	
49. SIGNATURE OF DECEASED J. J. JONES		50. SIGNATURE OF WITNESS J. J. JONES		51. SIGNATURE OF DECEASED J. J. JONES		52. SIGNATURE OF WITNESS J. J. JONES	
53. SIGNATURE OF DECEASED J. J. JONES		54. SIGNATURE OF WITNESS J. J. JONES		55. SIGNATURE OF DECEASED J. J. JONES		56. SIGNATURE OF WITNESS J. J. JONES	
57. SIGNATURE OF DECEASED J. J. JONES		58. SIGNATURE OF WITNESS J. J. JONES		59. SIGNATURE OF DECEASED J. J. JONES		60. SIGNATURE OF WITNESS J. J. JONES	
61. SIGNATURE OF DECEASED J. J. JONES		62. SIGNATURE OF WITNESS J. J. JONES		63. SIGNATURE OF DECEASED J. J. JONES		64. SIGNATURE OF WITNESS J. J. JONES	
65. SIGNATURE OF DECEASED J. J. JONES		66. SIGNATURE OF WITNESS J. J. JONES		67. SIGNATURE OF DECEASED J. J. JONES		68. SIGNATURE OF WITNESS J. J. JONES	
69. SIGNATURE OF DECEASED J. J. JONES		70. SIGNATURE OF WITNESS J. J. JONES		71. SIGNATURE OF DECEASED J. J. JONES		72. SIGNATURE OF WITNESS J. J. JONES	
73. SIGNATURE OF DECEASED J. J. JONES		74. SIGNATURE OF WITNESS J. J. JONES		75. SIGNATURE OF DECEASED J. J. JONES		76. SIGNATURE OF WITNESS J. J. JONES	
77. SIGNATURE OF DECEASED J. J. JONES		78. SIGNATURE OF WITNESS J. J. JONES		79. SIGNATURE OF DECEASED J. J. JONES		80. SIGNATURE OF WITNESS J. J. JONES	
81. SIGNATURE OF DECEASED J. J. JONES		82. SIGNATURE OF WITNESS J. J. JONES		83. SIGNATURE OF DECEASED J. J. JONES		84. SIGNATURE OF WITNESS J. J. JONES	
85. SIGNATURE OF DECEASED J. J. JONES		86. SIGNATURE OF WITNESS J. J. JONES		87. SIGNATURE OF DECEASED J. J. JONES		88. SIGNATURE OF WITNESS J. J. JONES	
89. SIGNATURE OF DECEASED J. J. JONES		90. SIGNATURE OF WITNESS J. J. JONES		91. SIGNATURE OF DECEASED J. J. JONES		92. SIGNATURE OF WITNESS J. J. JONES	
93. SIGNATURE OF DECEASED J. J. JONES		94. SIGNATURE OF WITNESS J. J. JONES		95. SIGNATURE OF DECEASED J. J. JONES		96. SIGNATURE OF WITNESS J. J. JONES	
97. SIGNATURE OF DECEASED J. J. JONES		98. SIGNATURE OF WITNESS J. J. JONES		99. SIGNATURE OF DECEASED J. J. JONES		100. SIGNATURE OF WITNESS J. J. JONES	

BUREAU V. 1

APR 8 1958

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05130

CERTIFICATE OF DEATH

5129

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>since 10/8/52</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lynch</u>		<u>14X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOSEPH</u>		(Middle) <u>EDWARD</u>		(Last) <u>MAGROGAN</u>		(Month) <u>Apr.</u> (Day) <u>8</u> (Year) <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 28, 1885</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Magrogan</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Irvin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Records of Pine Bluff State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>002X</u> IMMEDIATE CAUSE (A) <u>Pulmonary tuberculosis</u>						<u>6 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) _____							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) _____							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1957</u> , to <u>Apr. 8, 1958</u> , that I last saw the deceased alive on <u>Apr. 8, 1958</u> , and that death occurred at <u>4:36p.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>E.P. Ritchings</u>		ADDRESS (Street, city, town, state) <u>M.D. Pine Bluff State Hospital, Salisbury, Md.</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/12/58</u>		NAME OF CEMETERY OR CREMATORY <u>Church Hill Catholic</u>		LOCATION (City, town, or county) (State) <u>Church Hill (O.A. Co.) Maryland</u>	
24. REC'D BY REGISTRAR <u>APR 10 '58</u>		REGISTRAR'S SIGNATURE <u>W. J. Leach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wells Wells</u>		ADDRESS <u>Chestertown, Md.</u>	

Abstract

OVERVIEW

INDEX

APR 10 1964

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BUREAU V. 5

APR 10 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Route 12</i>		d. STREET ADDRESS <i>Rural #2</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>George R Taylor Mason</i>		4. DATE OF DEATH Month Day Year <i>April 5 1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 19-1938</i>
9. AGE (In years last birthday) <i>20 1/4 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Saw Mill</i>	
11. BIRTHPLACE (State or foreign country) <i>Snow Hill, md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George Edward Mason</i>		14. MOTHER'S MAIDEN NAME <i>Ida Taylor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>1-18-34-3243</i>	
17. INFORMANT <i>George Edward Mason</i>		Address <i>Snow Hill, md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage</i> <i>816X</i> DUE TO <i>Completely severed face</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Collision of two autos</i>	
20c. TIME OF INJURY Month, Day, Year <i>4-5 1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Rt 12</i>	20f. (City or town) <i>Salisbury</i> (County) <i>Wicomico</i> (State) <i>md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Earl L. Royer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Earl L. Royer</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>4-7-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>April 8 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Taylor Gate</i>	22d. LOCATION (City, town, or county) (State) <i>Snow Hill md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Way E. Dennis</i>		ADDRESS <i>Snow Hill, md</i>	
24a. REC'D BY REGISTRAR <i>APR 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>	

BUREAU

APR 9 1958

RECEIVED

5130 CERTIFICATE OF DEATH

05132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>5 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walden</u> Middle <u>BASIL</u> Last <u>Mezick</u>				4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/4/1901</u>	
9. AGE (In years lost birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>58</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-PRODUCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUYER</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>G. W. Mezick</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Ruark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>220 03 5483</u>		17. INFORMANT <u>Hospital Records</u> Address <u>Mrs. Mildred B. Mezick, Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6</u> days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 8</u> , 19 <u>53</u> , to <u>April 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 5</u> , 19 <u>58</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>4/5/58</u> ACTUAL SIGNATURE <u>L. V. Maldve</u> M.D. <u>Salisbury, Maryland</u> PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Fruitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co., Salisbury, Md.</u> ADDRESS <u>Norman G. Baker</u>				24a. REC'D BY REGISTRAR DATE <u>APR 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Albert Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 8 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05133

Reg. Dist. No.

5131

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parksley</u> 83 X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>Francis</u> Last <u>Miles</u>				4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30, 1912</u>		9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Willis Wharf, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Miles</u>				14. MOTHER'S MAIDEN NAME <u>Mrs Sallie Doughty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Lais Miles</u> Address <u>Hopetown, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Esophageal varices</u> DUE TO (c) <u>Cirrhosis of the liver</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-22-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/24/58</u>		<u>Parksley</u>		<u>Parksley</u> <u>Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Shivers by Richard Shivers</u>				24a. REC'D BY REGISTRAR <u>APR 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

• • • • •

BUREAU V. E.

APR 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5132 CERTIFICATE OF DEATH

Reg. Dist. No.

05134

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>6 1/2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Cooksville</u> <u>13x-2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Eleanor</u> Middle <u>Virginia</u> Last <u>Mills</u>				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/9/1908</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>50</u> Days <u>50</u> Hours <u>50</u> Min. <u>50</u>		IF UNDER 24 HRS. Months <u>50</u> Days <u>50</u> Hours <u>50</u> Min. <u>50</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Howard Mills</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unk.</u>				16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT <u>Hospital Records Address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Systemic lupus erythematosus</u> <u>705.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>?</u> DUE TO (c) <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple sclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Oct. 23</u> , 19 <u>51</u> , to <u>April 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 21</u> , 19 <u>58</u> , and that death occurred at <u>8:50 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. V. Juerman</u>				M.D. <u>Deer's Head State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>				22b. DATE THEREOF <u>4-24-58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>ANATOMICAL Bld. BALTO, MD.</u>				22d. LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>BOOKER M. WELLS</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 25 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

CERTIFICATE OF DEATH

Reg. No. 100

PLACE OF DEATH		MAYLAND	
CITY OR VILLAGE		BALTIMORE	
COUNTY		BALTIMORE	
STREET		1000 N. E. ST.	
APARTMENT		1000 N. E. ST.	
BUILDING		1000 N. E. ST.	
DECEASED		1000 N. E. ST.	
DATE OF DEATH		1000 N. E. ST.	
TIME OF DEATH		1000 N. E. ST.	
CAUSE OF DEATH		1000 N. E. ST.	
MANNER OF DEATH		1000 N. E. ST.	
AGE		1000 N. E. ST.	
SEX		1000 N. E. ST.	
RACE		1000 N. E. ST.	
EDUCATION		1000 N. E. ST.	
OCCUPATION		1000 N. E. ST.	
RELIGION		1000 N. E. ST.	
MARRIAGE		1000 N. E. ST.	
SINGLE		1000 N. E. ST.	
MARRIED		1000 N. E. ST.	
WIDOWED		1000 N. E. ST.	
DIVORCED		1000 N. E. ST.	
SEPARATED		1000 N. E. ST.	
RECEIVED		1000 N. E. ST.	
BUREAU V. S.		1000 N. E. ST.	
APR 28 1958		1000 N. E. ST.	

RECEIVED

APR 28 1958

BUREAU V. S.

5133

CERTIFICATE OF DEATH

05135

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>3V01-4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>5 weeks</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				d. STREET ADDRESS <u>1711 1/2 Kingsway</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Hill Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William Raymond</u> Middle <u>North</u> Last <u>North</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 12, 1871</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sales engineer (rtd)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u> </u>			
13. FATHER'S NAME <u>Thomas Levin North</u>				14. MOTHER'S MAIDEN NAME <u>Mary Maith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mrs. Elizabeth Wilson - Delmar, Del.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X/diabetes - Cardiovascular renal disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb. 23</u> , 19 <u>58</u> , to <u>April 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-31</u> , 19 <u>58</u> , and that death occurred at <u>8 A. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>116 E. Main St. Salisbury, Md.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Philip A. Insley</u> M.D. <u> </u>							
PHYSICIAN'S NAME (Type) <u>Dr. Philip A. Insley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. J. L. Baker & Sons - Baltimore</u> ADDRESS <u> </u>							
24a. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>				24b. REGISTRAR'S SIGNATURE <u> </u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05136

5134

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Va. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 Year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium		d. STREET ADDRESS Onley, Va. 83x-3	
3. NAME OF DECEASED (Type or print) First Edward Middle J. Last O'Donovan		4. DATE OF DEATH Month April Day 25th Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Baltimore County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward O'Donovan		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x DUE TO Cardio-vascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 23, 19 57 to 4-25 , 19 58 , that I last saw the deceased alive on 4-24 , 19 58 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip A. Insley		ADDRESS (Street, city or town, state) Salisbury Md. DATE SIGNED 4-25-58	
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-58	
22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Long Green Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co. ADDRESS 4905 York Rd. Balto. 12, Md.		24a. REC'D BY REGISTRAR APR 29 '58 24b. REGISTRAR'S SIGNATURE W. H. Jenkins	

4905 York Road - Balto. 12, Md.

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1883		NEW YORK		NEW YORK		NEW YORK	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1905		NEW YORK		NEW YORK		NEW YORK		1928		NEW YORK		NEW YORK	
OCCUPATION		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
CLOCK REPAIRER		1928		NEW YORK		NEW YORK		NEW YORK		1928		NEW YORK		NEW YORK	
CAUSE OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		1928		NEW YORK		NEW YORK		NEW YORK		1928		NEW YORK		NEW YORK	
MANNER OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
NATURAL		1928		NEW YORK		NEW YORK		NEW YORK		1928		NEW YORK		NEW YORK	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. H. HARRIS		1928		NEW YORK		NEW YORK		NEW YORK		1928		NEW YORK		NEW YORK	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. H. HARRIS		1928		NEW YORK		NEW YORK		NEW YORK		1928		NEW YORK		NEW YORK	

BUREAU N. Y.

APR 29 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05137

5135

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>533 WAILES ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>BARBARA</u> Middle <u>ANN</u> Last <u>OWENS</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1957</u>
9. AGE (In years last birthday) <u>0</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>17</u>	
IF UNDER 24 HRS. Hours <u>17</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Harry B. OWENS</u>		14. MOTHER'S MAIDEN NAME <u>Helen Brittingham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Mr. Harry B. Owens (Father)</u>	
17. INFORMANT <u>Salisbury, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephritis Acute</u> DUE TO <u>Virus infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/6</u> , 19 <u>58</u> , to <u>4/7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/6</u> , 19 <u>58</u> , and that death occurred at <u>2:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town; state) <u>Med. Center, Salisbury, Md.</u> DATE SIGNED <u>4/8/58</u>			
ACTUAL SIGNATURE <u>Dr. William B. Smith</u> M.D.		DATE SIGNED <u>4/8/58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William B. Smith</u>		Medical Center Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 9, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLL WAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>APR 11 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. B. Smith</u>	

2082272 XV6

CERTIFICATE OF DEATH



BUREAU Y. B.

APR 17 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5136

CERTIFICATE OF DEATH

Reg. Dist. No.

05140

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1002 Cecil St		d. STREET ADDRESS 1002 Cecil St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle KNIGHT Last SINGLETON		4. DATE OF DEATH Month April Day 23 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1865
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John V. Singleton		14. MOTHER'S MAIDEN NAME Elenor Sipplee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Edward S. Singleton (Son)		Address 1002 Cecil St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/28/58 to 4/23/58 , that I last saw the deceased alive on 4/24/58 , and that death occurred at 10:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Maryland Ave. Salisbury, Md DATE SIGNED Apr 24/58			
ACTUAL SIGNATURE Dr. Andrew C. Mitchell M.D.			
PHYSICIAN'S NAME (Type) Dr. O.J. Burton			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 25, 1958	
22c. NAME OF CEMETERY OR CREMATORY West Laurel Hill Cem.		22d. LOCATION (City, town, or county) (State) Philadelphia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE APR 25 '58		24b. REGISTRAR'S SIGNATURE Alberich	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

CERTIFICATE OF DEATH—BALTIMORE, 18

Item 12, File G228, 4/28/58 for

CERTIFICATE OF DEATH

05141

Reg. Dist. No.

5137

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN IB <u>6 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Staub</u> Last <u>Staub</u>				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/22/1914</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>			
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>			
13. FATHER'S NAME <u>Michael Staub</u>				14. MOTHER'S MAIDEN NAME <u>Mary Thoma</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Hospital Records</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor pulmonale</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>State after CVA with rt. hemiplegia; cachexia; congenital mental def.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Oct. 16</u> , 19 <u>57</u> , to <u>April 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 21</u> , 19 <u>58</u> , and that death occurred at <u>2:05 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>4/21/58</u> ACTUAL SIGNATURE <u>Gerhard Kosmahly</u> M.D. PHYSICIAN'S NAME (Type) <u>Gerhard Kosmahly, M.D.</u> <u>Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 23, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Belair Road.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Eason</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

BUREAU V. S.

APR 22 1922

RECEIVED

5138 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>222 Monticello Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>ELIZABETH</u> Last <u>Stevens</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 2, 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>29</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wisconsin</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Totman</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Groom</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Dr. Lella Stevens (Daughter)</u> Address <u>222 Monticello Ave. Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, Acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Dis.</u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/29</u> , 19 <u>58</u> , to <u>4/1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/31</u> , 19 <u>58</u> , and that death occurred at <u>12:45</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Pinchbluff Rd. Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>		DATE SIGNED <u>4/1/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 3, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>DATE APR 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Gardner</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2188

Form 100-100



DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
EDUCATION		OCCUPATION	
PREVIOUS ILLNESS		HISTORY OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF DECEASED		NAME OF WITNESS	
ADDRESS OF DECEASED		ADDRESS OF WITNESS	
CITY OF DECEASED		CITY OF WITNESS	
STATE OF DECEASED		STATE OF WITNESS	
COUNTRY OF DECEASED		COUNTRY OF WITNESS	
DATE OF BIRTH		DATE OF DEATH	
TIME OF BIRTH		TIME OF DEATH	
PLACE OF BIRTH		PLACE OF DEATH	
CAUSE OF BIRTH		CAUSE OF DEATH	
MANNER OF BIRTH		MANNER OF DEATH	
AGE AT BIRTH		AGE AT DEATH	
SEX AT BIRTH		SEX AT DEATH	
RACE AT BIRTH		RACE AT DEATH	
RELIGION AT BIRTH		RELIGION AT DEATH	
OCCUPATION AT BIRTH		OCCUPATION AT DEATH	
PREVIOUS ILLNESS AT BIRTH		PREVIOUS ILLNESS AT DEATH	
SIGNATURE OF DECEASED AT BIRTH		SIGNATURE OF DECEASED AT DEATH	
DATE OF SIGNATURE AT BIRTH		DATE OF SIGNATURE AT DEATH	
PLACE OF SIGNATURE AT BIRTH		PLACE OF SIGNATURE AT DEATH	
NAME OF DECEASED AT BIRTH		NAME OF DECEASED AT DEATH	
ADDRESS OF DECEASED AT BIRTH		ADDRESS OF DECEASED AT DEATH	
CITY OF DECEASED AT BIRTH		CITY OF DECEASED AT DEATH	
STATE OF DECEASED AT BIRTH		STATE OF DECEASED AT DEATH	
COUNTRY OF DECEASED AT BIRTH		COUNTRY OF DECEASED AT DEATH	

BUREAU V. S.

APR 7 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05144

CERTIFICATE OF DEATH

5139

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seaford</u> 46x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>314 DuPont Road</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Thompson</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23, 1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Hat Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hat Maker</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Mrs. Mary Thompson, Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unresolved lobar pneumonia</u> 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-2-</u> , 19 <u>58</u> , to <u>3-19-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-19</u> , 19 <u>58</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilbur R. Ellis Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>4-19-58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Wilbur R. Ellis Jr. Medical Center, Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>4-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulchre</u>		22d. LOCATION (City, town, or county) (State) <u>Montgo Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson</u> ADDRESS <u>Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>APR 22 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. B. Smith</u>	

Norman F. Baker

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		12-1-28		MOBILE, ALABAMA	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MARRIED		1954		MEMPHIS, TENNESSEE		4-4-68		MEMPHIS, TENNESSEE		SHOOTING	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
CONDUCTOR		4-4-68		MEMPHIS, TENNESSEE		4-4-68		MEMPHIS, TENNESSEE		SHOOTING	
EDUCATION		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
HIGH SCHOOL		4-4-68		MEMPHIS, TENNESSEE		4-4-68		MEMPHIS, TENNESSEE		SHOOTING	
RELIGION		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
METHODIST		4-4-68		MEMPHIS, TENNESSEE		4-4-68		MEMPHIS, TENNESSEE		SHOOTING	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
4-4-68		MEMPHIS, TENNESSEE		4-4-68		MEMPHIS, TENNESSEE		4-4-68		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
SHOOTING		MEMPHIS, TENNESSEE		4-4-68		MEMPHIS, TENNESSEE		4-4-68		MEMPHIS, TENNESSEE	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
4-4-68		MEMPHIS, TENNESSEE		4-4-68		MEMPHIS, TENNESSEE		4-4-68		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
SHOOTING		MEMPHIS, TENNESSEE		4-4-68		MEMPHIS, TENNESSEE		4-4-68		MEMPHIS, TENNESSEE	

BUREAU V. 1

APR 22 1968

RECEIVED

James P. O'Connell

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5140

CERTIFICATE OF DEATH

Reg. Dist. No.

05145

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last THEODORE MARION TILGHMAN				4. DATE OF DEATH Month Day Year 4 9 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1888	9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Superint Jr. High School				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Jason Tilghman				14. MOTHER'S MAIDEN NAME Louise Adkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Mary Ford, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, Acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Arteriosclerotic Cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH 1 day 7 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/8 , 19 58 , to 4/9 , 19 58 , that I last saw the deceased alive on 4/9 , 19 58 , and that death occurred at 9:20A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 4/9/58							
ACTUAL SIGNATURE Thomas C. Hill M.D. Salisbury, Maryland							
PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill Pine Buff Rd., Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/58		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Pk.		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE APR 14 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Norman T. Baker

• *Journal of Management Education*

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05146

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 12</u>		d. STREET ADDRESS <u>Rural #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edward</u> Last <u>Ward II</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26-1939</u>
9. AGE (In years last birthday) <u>18 11/9</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>College</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Edward Ward</u>		14. MOTHER'S MAIDEN NAME <u>Margie E. Leheris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>James Edward Ward</u> Address <u>Chattanooga, MD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Crushed Chest</u> <u>Rural #1</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Shooter</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Head or collision with car</u>	
20c. TIME OF INJURY Month, Day, Year <u>9-5</u> a.m. <u>4-5</u> p.m. <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt. 12</u>		20f. City or town <u>Salisbury</u> (County) <u>Queen Anne</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 9/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Snow Hill Memorial</u>		22d. LOCATION (City, town, or county) <u>Snow Hill</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay E. Sumner</u> ADDRESS <u>Snow Hill, MD</u>		24a. REC'D BY REGISTRAR <u>APR 9 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Clay E. Sumner</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU K. B.

APR 9 1958

RECEIVED

ORIGINAL FILED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05147

Reg. Dist. No.

5142

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY</u> 2342.2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>204 LAUREL STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>SIM</u> Middle <u>S.</u> Last <u>WARD</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 19, 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAITUEL S. WARD</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH TAYLOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>214-12-6490</u>	
17. INFORMANT <u>MRS ROSE D. WARD, Pocomoke City, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion, acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Peripartur Circulatory Collapse</u> DUE TO <u>5 days</u> (c) <u>Anteroselective Cardiovascular Dis</u> <u>2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old Myocardial Infarction (55 2)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/24</u> , 19 <u>58</u> to <u>4/1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/1</u> , 19 <u>58</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>PINEBLUFF Rd.</u> DATE SIGNED <u>4/1/58</u>	
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u> <u>SALISBURY, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-4-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SALEM METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>POCOMOKE CITY, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Deborah</u>			

APR 7 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05148

5143

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 27 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Thomas Last Watkins		4. DATE OF DEATH Month April Day 6 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1894
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 6 Hours 19 Min. 58	IF UNDER 24 HRS. Months 63 Days 6 Hours 19 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Irvin Thomas		14. MOTHER'S MAIDEN NAME Bailey Berlin, Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Bernice Horsemann (Daughter)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 10, 1958 to April 6, 1958 that I last saw the deceased alive on April 6, 1958 and that death occurred at 10:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 4/7/58			
ACTUAL SIGNATURE L. V. Maldve, M. D.		M.D. Salisbury, Maryland	
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		Deer's Head State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 9, 1958	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR APR 11 '58		24b. REGISTRAR'S SIGNATURE Deer's Head	

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 67 years		4. DATE OF BIRTH March 15, 1871	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Retired	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE June 10, 1905	
9. NAME OF SPOUSE Mary E. Harris		10. DATE OF DEATH April 11, 1938	
11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY Hypertension, Atherosclerosis		14. PRESENT ILLNESS Myocardial Infarction	
15. PHYSICIAN Dr. J. H. Smith		16. HOSPITAL None	
17. BURIAL PLACE Catholic Cemetery		18. SIGNATURE OF PHYSICIAN J. H. Smith	
19. SIGNATURE OF REGISTRAR J. H. Smith		20. OFFICIAL SEAL	

RECEIVED
APR 11 1938
BUREAU V. 8

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05149

CERTIFICATE OF DEATH

5144

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 11/24/57</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Secretary</u>		✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>09X-2</u>			
3. NAME OF DECEASED (Type or Print) <u>Eleanor Nevada Webster</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 7 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 23, 1907</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Work</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Secretary, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Webster</u>				14. MOTHER'S MAIDEN NAME <u>Genevieve Phelan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>462-16-5545</u>		17. INFORMANT & ADDRESS <u>Records of Pine Bluff State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						<u>18 years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 24, 1957</u> , to <u>April 7, 1958</u> , that I last saw the deceased alive on <u>April 7, 1958</u> , and that death occurred at <u>1:47 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>E. P. Ritchings</u>				DATE SIGNED <u>April 7, 1958</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR			
DATE THEREOF <u>4/9/58</u>				REGISTRAR'S SIGNATURE			
NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>				LOCATION (City, town, or county) <u>Secretary, Md</u>			
25. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
<u>W. S. McElroy & Son</u>							
DATE <u>APR 9 '58</u>							

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05150

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 1 Salisbury		e. STREET ADDRESS R.D.# 1 Salisbury	
3. NAME OF DECEASED (Type or print) First MARTHA Middle LETITIA Last WHAYLAND		4. DATE OF DEATH Month APRIL Day 1 st Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1874
9. AGE (in years last birthday) 83 yrs.		IF UNDER 1 YEAR 6 Months 7 Days IF UNDER 24 HRS. 6 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY Quantico, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Marcellus Windsor Bailey		14. MOTHER'S MAIDEN NAME Mary Frances Bradley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr Wakeman Whayland (Son) 410 Dover St. Salisbury, Maryland	
17. INFORMANT Mr Wakeman Whayland (Son) 410 Dover St. Salisbury, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic C. V. Disease DUE TO you Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 4, 1958	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR APR 7 '58 24b. REGISTRAR'S SIGNATURE W. J. Seach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

1

BUREAU V. 2

APR 7 1958

RECEIVED

5145

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				e. STREET ADDRESS R.D.# 1(Snow Hill Rd)			
3. NAME OF DECEASED (Type or print) First JAMES Middle CLAY Last WHITE				4. DATE OF DEATH Month APRIL Day 8th Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 8 Days 27		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant(Operated Own Store)				10b. KIND OF BUSINESS OR INDUSTRY Siloam, Maryland		11. BIRTHPLACE (State or foreign country) U S A	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Joseph C. White				14. MOTHER'S MAIDEN NAME Wilianna Seabrease			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Martha White (Wife)				Address R.D.# 1(Snow Hill Road) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) 5 yrs							INTERVAL BETWEEN ONSET AND DEATH 70 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 19 56 to April 8, 19 58 , that I last saw the deceased alive on March 19 58 , and that death occurred at 10:53 P from the causes and on the date stated above.							
ACTUAL SIGNATURE D. V. Sohler M.D.				ADDRESS (Street, city or town, state) Delmar, Maryland			
DATE SIGNED April 10 1958							
PHYSICIAN'S NAME (Type) Dr. L. V. Sohler							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 11, 1958		22c. NAME OF CEMETERY OR CREMATORY Siloam Cemetery		22d. LOCATION (City, town, or county) (State) Siloam, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR APR 11 '58	
24b. REGISTRAR'S SIGNATURE Delmar							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2125

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

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BUREAU V. 3

APR 11 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05152

5146

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>R.D.# 3 Delmar Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>ALBERTA</u> Last <u>White</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1917</u>
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Accomac Co. Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Neal C. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Mary Louise Hastings</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Mr. Ernest L. White (Husband)</u> Address <u>R.D.# 3 Delmar Road Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> <u>757.1</u> DUE TO (b) <u>Acute and Chronic pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Polycystic Kidney Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>20 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/15/1958</u> to <u>4/1/1958</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>11:58 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Raymond M. Yow</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Dr. Raymond M. Yow</u>		<u>Salisbury, Maryland</u> <u>Apr. 1, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 4, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. L. Beach</u>

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. S.

APR 7 1958

RECEIVED

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mirrored and difficult to read.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05153

5147

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>2 Quince Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VICKIE</u> Middle <u>LYNN</u> Last <u>White</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28, 1958-10 AM</u>
9. AGE (In years last birthday) yrs. <u>23</u>		IF UNDER 1 YEAR Months <u>23</u> Days <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James Ronald White</u>		14. MOTHER'S MAIDEN NAME <u>Deanna Bozman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. James R. White (Father) R.D.# 5 Salisbury, Maryland</u>	
17. INFORMANT <u>Mr. James R. White (Father) Salisbury, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x prematurity</u> DUE TO (b) <u>23 hrs</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 28</u> , 1958, to <u>April 29</u> , 1958, that I last saw the deceased alive on <u>April 29</u> , 1958, and that death occurred at <u>9:25 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert E. Herndon</u> M.D.		ADDRESS (Street, city or town, state) <u>702 Camden Ave., Salisbury, Md.</u> DATE SIGNED <u>April 29, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Robert E. Herndon</u>		Camden Ave. Salisbury April 29, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 30, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>MAY 2 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Robert E. Herndon</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, may be required by the hospital or attending physician. Pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5148 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> 19x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>A.Z.D. #3</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Wilson</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 30 1905</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mechanics</u>	
11. BIRTHPLACE (State or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leopold Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Theodosia Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-16-9888</u>	
17. INFORMANT <u>Charles Wilson Primer one</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Schum</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4/15/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4-26-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oratio Cemetery</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leopold Wilson Primer one</u>		24a. REC'D BY REGISTRAR <u>APR 21 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Al Schum</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

05155

Reg. Dist. No.

5149

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oriole, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 322 Carrollton Ave.				d. STREET ADDRESS 322 Carrollton Ave.			
3. NAME OF DECEASED (Type or print) First Dwight Middle Oliver Last Wilson Sr.				4. DATE OF DEATH Month April Day 5 Year 19 58			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1879	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 9 Hours 19 Min.		IF UNDER 24 HRS. Months 7 Days 9 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
						12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Wilson				14. MOTHER'S MAIDEN NAME Margaret Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 218-09-7834		17. INFORMANT Donald Wison 322 Carrollton Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarct, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4-5 , 19 58 , to 4-5 , 19 58 , that I last saw the deceased alive on 4-5 , 19 58 , and that death occurred at 11 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter R. Ellis, Jr. M.D.				ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 4-8-58			
PHYSICIAN'S NAME (Type) Walter R. Ellis, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/8/58		22c. NAME OF CEMETERY OR CREMATORY Oriole Cemetery		22d. LOCATION (City, town, or county) (State) Oriole, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James Henson ADDRESS Princess Anne, Md.				24a. REC'D BY REGISTRAR DATE APR 9 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5150 CERTIFICATE OF DEATH

05156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 36 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS --			
3. NAME OF DECEASED (Type or print) First Joseph Middle Franklin Last Wilson				4. DATE OF DEATH Month April Day 17 , Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 1, 1918	
9. AGE (In years last birthday) yrs. 40		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman				10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joseph Lee Wilson				14. MOTHER'S MAIDEN NAME Nannie Marie Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk				16. SOCIAL SECURITY NO. 212-C3-2865		17. INFORMANT Deer's Head State Hospital, Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent bronchopneumonia 491x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) State after craniotomy due to ruptured cerebral aneurysm							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 12, 1958 , to April 17, 1958 , that I last saw the deceased alive on April 17, 1958 , and that death occurred at 12:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 4/17/58							
ACTUAL SIGNATURE G. Kosmahly M.D. Deer's Head State Hospital				DATE SIGNED 4/17/58			
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) April 19, 58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Tilghman Methodist		22d. LOCATION (City, town, or county) (State) Tilghman Talbot	
23. FUNERAL DIRECTOR'S SIGNATURE Deer's Head State Hospital				24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE W. L. L. L.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5100

Reg. Dist. No.

Dec. No.

Reg. No.

Reg. No.

Reg. No.

Reg. No.

Reg. No.

Reg. No.

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Reg. No.

Reg. No.

Reg. No.

BUREAU V. 8

APR 21 1958

RECEIVED

CERTIFICATE OF DEATH

05157

Reg. Dist. No.

5162

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs		c. LENGTH OF STAY IN TB 64 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Wilson Last Wright		4. DATE OF DEATH Month April Day 17 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1894
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Mardela Springs, Md
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William T. Wilson	
14. MOTHER'S MAIDEN NAME Samanatha Cooper		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Franklin Wright, Mardela Springs, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 3 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 15, 1958 , to April 17, 1958 , that I last saw the deceased alive on April 16, 1958 , and that death occurred at 2 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. S. Kuhlman		ADDRESS (Street, city or town, state) Shaptown Md	
PHYSICIAN'S NAME (Type) H. S. Kuhlman		DATE SIGNED 4/18/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-20-58	22c. NAME OF CEMETERY OR CREMATORY Mardela	22d. LOCATION (City, town, or county) (State) Mardela Springs, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Marvel, Shaptown, Md.		24a. REC'D BY REGISTRAR APR 21 '58	24b. REGISTRAR'S SIGNATURE Alfred Smith

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DEATH: [illegible]
 SEX: [illegible] AGE: [illegible]
 DATE OF BIRTH: [illegible]
 PLACE OF BIRTH: [illegible]
 OCCUPATION: [illegible]
 CAUSE OF DEATH: [illegible]
 PLACE OF DEATH: [illegible]
 TIME OF DEATH: [illegible]
 SIGNATURE: [illegible]
 DATE: [illegible]

BUREAU V. 1

APR 21 1958

RECEIVED

RECEIVED

5151 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md.</u>				c. LENGTH OF STAY IN 1b <u>749 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Trappe</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Pinkney</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 15, 1875</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Collison</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Lizzie Connelley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records, Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 26</u> , 19 <u>56</u> , to <u>April 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 14</u> , 19 <u>58</u> , and that death occurred at <u>11:50A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Deer's Head State Hospital</u> <u>4/14/58</u>							
ACTUAL SIGNATURE <u>L. V. Maldve, M. D.</u>				M.D. <u>Deer's Head State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>				Deer's Head State Hospital, Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 15 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>F. C. U. A. M. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Picton</u> <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Hamilton</u>				ADDRESS <u>Harrison, St. Michaels</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-1

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. OCCUPATION		11. EDUCATION		12. MARITAL STATUS	
13. PREVIOUS ILLNESS		14. PRESENT ILLNESS		15. DATE OF ONSET	
16. PHYSICIAN'S SIGNATURE		17. MEDICAL EXAMINER'S SIGNATURE		18. COUNTY	
19. CITY		20. STATE		21. ZIP CODE	
22. REGISTRAR'S SIGNATURE		23. REGISTRAR'S TITLE		24. DATE OF REGISTRATION	
25. COUNTY		26. CITY		27. STATE	
28. ZIP CODE		29. COUNTY		30. CITY	
31. STATE		32. ZIP CODE		33. COUNTY	
34. CITY		35. STATE		36. ZIP CODE	
37. COUNTY		38. CITY		39. STATE	
40. ZIP CODE		41. COUNTY		42. CITY	
43. STATE		44. ZIP CODE		45. COUNTY	
46. CITY		47. STATE		48. ZIP CODE	
49. COUNTY		50. CITY		51. STATE	
52. ZIP CODE		53. COUNTY		54. CITY	
55. STATE		56. ZIP CODE		57. COUNTY	
58. CITY		59. STATE		60. ZIP CODE	
61. COUNTY		62. CITY		63. STATE	
64. ZIP CODE		65. COUNTY		66. CITY	
67. STATE		68. ZIP CODE		69. COUNTY	
70. CITY		71. STATE		72. ZIP CODE	
73. COUNTY		74. CITY		75. STATE	
76. ZIP CODE		77. COUNTY		78. CITY	
79. STATE		80. ZIP CODE		81. COUNTY	
82. CITY		83. STATE		84. ZIP CODE	
85. COUNTY		86. CITY		87. STATE	
88. ZIP CODE		89. COUNTY		90. CITY	
91. STATE		92. ZIP CODE		93. COUNTY	
94. CITY		95. STATE		96. ZIP CODE	
97. COUNTY		98. CITY		99. STATE	
100. ZIP CODE		101. COUNTY		102. CITY	
103. STATE		104. ZIP CODE		105. COUNTY	
106. CITY		107. STATE		108. ZIP CODE	
109. COUNTY		110. CITY		111. STATE	
112. ZIP CODE		113. COUNTY		114. CITY	
115. STATE		116. ZIP CODE		117. COUNTY	
118. CITY		119. STATE		120. ZIP CODE	
121. COUNTY		122. CITY		123. STATE	
124. ZIP CODE		125. COUNTY		126. CITY	
127. STATE		128. ZIP CODE		129. COUNTY	
130. CITY		131. STATE		132. ZIP CODE	
133. COUNTY		134. CITY		135. STATE	
136. ZIP CODE		137. COUNTY		138. CITY	
139. STATE		140. ZIP CODE		141. COUNTY	
142. CITY		143. STATE		144. ZIP CODE	
145. COUNTY		146. CITY		147. STATE	
148. ZIP CODE		149. COUNTY		150. CITY	
151. STATE		152. ZIP CODE		153. COUNTY	
154. CITY		155. STATE		156. ZIP CODE	
157. COUNTY		158. CITY		159. STATE	
160. ZIP CODE		161. COUNTY		162. CITY	
163. STATE		164. ZIP CODE		165. COUNTY	
166. CITY		167. STATE		168. ZIP CODE	
169. COUNTY		170. CITY		171. STATE	
172. ZIP CODE		173. COUNTY		174. CITY	
175. STATE		176. ZIP CODE		177. COUNTY	
178. CITY		179. STATE		180. ZIP CODE	
181. COUNTY		182. CITY		183. STATE	
184. ZIP CODE		185. COUNTY		186. CITY	
187. STATE		188. ZIP CODE		189. COUNTY	
190. CITY		191. STATE		192. ZIP CODE	
193. COUNTY		194. CITY		195. STATE	
196. ZIP CODE		197. COUNTY		198. CITY	
199. STATE		200. ZIP CODE		201. COUNTY	
202. CITY		203. STATE		204. ZIP CODE	
205. COUNTY		206. CITY		207. STATE	
208. ZIP CODE		209. COUNTY		210. CITY	
211. STATE		212. ZIP CODE		213. COUNTY	
214. CITY		215. STATE		216. ZIP CODE	
217. COUNTY		218. CITY		219. STATE	
220. ZIP CODE		221. COUNTY		222. CITY	
223. STATE		224. ZIP CODE		225. COUNTY	
226. CITY		227. STATE		228. ZIP CODE	
229. COUNTY		230. CITY		231. STATE	
232. ZIP CODE		233. COUNTY		234. CITY	
235. STATE		236. ZIP CODE		237. COUNTY	
238. CITY		239. STATE		240. ZIP CODE	
241. COUNTY		242. CITY		243. STATE	
244. ZIP CODE		245. COUNTY		246. CITY	
247. STATE		248. ZIP CODE		249. COUNTY	
250. CITY		251. STATE		252. ZIP CODE	
253. COUNTY		254. CITY		255. STATE	
256. ZIP CODE		257. COUNTY		258. CITY	
259. STATE		260. ZIP CODE		261. COUNTY	
262. CITY		263. STATE		264. ZIP CODE	
265. COUNTY		266. CITY		267. STATE	
268. ZIP CODE		269. COUNTY		270. CITY	
271. STATE		272. ZIP CODE		273. COUNTY	
274. CITY		275. STATE		276. ZIP CODE	
277. COUNTY		278. CITY		279. STATE	
280. ZIP CODE		281. COUNTY		282. CITY	
283. STATE		284. ZIP CODE		285. COUNTY	
286. CITY		287. STATE		288. ZIP CODE	
289. COUNTY		290. CITY		291. STATE	
292. ZIP CODE		293. COUNTY		294. CITY	
295. STATE		296. ZIP CODE		297. COUNTY	
298. CITY		299. STATE		300. ZIP CODE	

BUREAU V. 1

APR 21 1958

RECEIVED